Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CEDARS SINAI MEDICAL CENTER
3505 CADILLAC SUITE L-4
COSTA MESA CA 92626

Respondent Name

MIDWEST EMPLOYERS CASUALTY CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-4116-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Contract allows 80% of TC."

Amount in Dispute: $65,368.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The DWC-60 indicates the Requestor did not file its request until July 14, 2011. DWC rules require the dispute be received by the DWC no later than one year after the date(s) of service in dispute. 28 TAC §133.307(c)(1)(A). The first date of service on the Table of Disputed Services is March 22, 2009. This claim was not timely filed."

Response Submitted by: Flahive, Ogden & Latson, Attorneys At Law, P. O. Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2009 Through March 27, 2009	Inpatient Hospital Surgical Services	$65,368.94	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason code:

   Explanation of benefits dated June 9, 2009

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Use Group Codes PR or CO depending upon liability).
- W1 – Workers Compensation State Fee Schedule Adjustment.
- W1 – Workers Compensation State Fee Schedule Adjustment. $0.00
- W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- 100 – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE.
- 112-011 – THE BILL HAS BEEN REIMBURSED ACCORDING TO THE PROVIDER'S CONTRACT WITH: First Health.
- 649 – REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE.
- 900 – BASED ON FURTHER REIVEW, NO ADDITIONAL ALLOWANCE IS WARRANTED.
- 975-641 – NURSE REVIEW DRG HOSPITAL BILL OR EXEMPT UNIT/FACILITY.
- 868-001 – HOSPITAL STAY IN PART OR TOTAL, AND OR PROCEDURE(S) AND OR ITEM(S), NOT PRE-CERTIFIED AND/OR AUTHORIZED. $0.00
- 868 – PER DRG PAYMENT METHODOLOGY, THE INITIALLY SUBMITTED CHARGES AND ADDITIONAL LATE CHARGES BILLED ARE INCLUDED IN THE ORIGINAL DRG ALLOWANCE $0.00.
- 958-100 – LATE CHARGES/ADDITIONAL CHARGES REVIEWED.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. $0.00.
- BILL NOTES; DENIAL #1 06/05/09:
  THE SUBMITTED HOSPITAL BILL HAS BEEN RE-EVALUATED BY BROADSPIRE, CLAIMS ARE REVIEWED ACCORDING TO THE ESTABLISHED GUIDELINES SET FORTH IN THE CALIFORNIA OFFICIAL MEDICAL FEE SCHEDULE.
  THE ORIGINAL BILL WAS PROCESSED CORRECTLY FOR DRG 541 USING MEDICARE PROVIDER #050825: 1.2 x 8582.01 x 0.9265 = 9541.48.; THE FOLLOWING CALCULATIONS DETERMINED THIS CLAIM IS NOT A COST OUTLIER CASE: BILLED CHARGES $85,435.07 x CCR 0.222 = COSTS $18,966.59
  BASIC FEE $9541.48 + OUTLIER FACTOR $22,870.91 = OUTLIER THRESHOLD $32,412.39
  COSTS $18,966.59 ARE LESS THAN OUTLIER THRESHOLD $32,412.39; THEREFORE, NOT A COST OUTLIER CASE.
  CALIFORNIA CODE OF REGULATIONS, TITLE 8, SECTION 9792.1(A) STATES, "…THE FEE DETERMINED UNDER THIS SUBDIVISION SHALL BE A GLOBAL FEE, CONSTITUTING THE MAXIMUM REIMBURSEMENT TO A HEALTH FACILITY FOR INPATIENT MEDICAL SERVICES…" THEREFORE, NO FURTHER REIMBURSEMENT IS DUE.
  THE CODE OF REGULATIONS STATES: "ANY HEALTH CARE FACILITY THAT BELIEVES ITS COMPOSITE FACTOR WAS ERRONEOUSLY DETERMINED BECAUSE OF AN ERROR IN TABULATING DATA MAY REQUEST THE ADMINISTRATIVE DIRECTOR FOR A RE-DETERMINATION OF ITS COMPOSITE FACTOR."

Explanation of benefits dated May 25, 2010

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W1 – Workers Compensation State Fee Schedule Adjustment.
- W1 – Workers Compensation State Fee Schedule Adjustment. $0.00
- 649 – REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE.
- 900 – BASED ON FURTHER REVIEW, NO ADDITIONAL ALLOWANCE IS WARRANTED.
- 975-641 – NURSE REVIEW DRG HOSPITAL BILL OR EXEMPT UNIT/FACILITY.
- 868-001 – HOSPITAL STAY IN PART OR TOTAL, AND OR PROCEDURE(S) AND OR ITEM(S), NOT PRE-CERTIFIED AND/OR AUTHORIZED. $0.00
- 868 – PER DRG PAYMENT METHODOLOGY, THE INITIALLY SUBMITTED CHARGES AND ADDITIONAL LATE CHARGES BILLED ARE INCLUDED IN THE ORIGINAL DRG ALLOWANCE $0.00.
- 958-100 – LATE CHARGES/ADDITIONAL CHARGES REVIEWED.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. $0.00.
- BILL NOTES:
  Coventry Message – DCHG – REVISED DATA
  Coventry Message – EPFH – The charges have been priced in accordance with a First Health owned contract. For questions, Please Call 1-800-937-6824.
  Coventry Message – REFS – REIMBURSEMENT FOR THIS BILL IS TO BE THE FIRST HEALTH RATE

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute are March 22, 2009 through March 27, 2009. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on July 14, 2011. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

		January 10, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		January 10, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.